Medicaid Information Bulletin

April 2003

Web address: http://health.utah.gov/medicaid

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BULLETINS BY TYPE OF SERVICE

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03 - 05 Medicaid Budget Hearing for Fiscal Year 2005

The Department of Health invites you to attend a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid budget for Fiscal Year 2005. The meeting will be held Thursday, June 19, 2003 from 4:00 p.m. until 6:00 p.m. in room 114 of the Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah.

Fiscal Year 2005 is July 1, 2004 through June 30, 2005. The MCAC is an advisory group which recommends funding and program directions to the Department of Health and the Governor.

If you know of special medical needs not being met by the Medicaid, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid providers and clients.

If you cannot attend the public hearing, but would like to write to the Committee about special medical needs, please mail comments to:

MCAC
Box 143103
Salt Lake City, UT 84114-3103

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03 - 06 Two Medicaid Information Bulletins Issued in February 2003

In February 2003, the following bulletins were issued:

03 - 03 Hospital Services: Billing Observation Room Charges. Bulletin was issued to hospitals only. A copy of the bulletin is on-line at http://health.utah.gov/medicaid/january2003OR.pdf

03 - 04 Copayment/Co-insurance Policy. Bulletin was issued to providers who require a co-pay or coinsurance. A copy of the bulletin is on-line at

http://health.utah.gov/medicaid/january2003OR.pdf

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03 - 07 Care Coordination for IHC Access PPN Enrollees

Children and pregnant women enrolled in IHC Access may still receive care coordination. Children receive care coordination through IHC pediatric care coordinators. Contact one of the following care coordinators to refer IHC Access enrollees for care coordination:

Cathi Hall (Weber and Davis Counties) 1-801-387-4705
Fax 1-801-387-4712 Beeper 914-7941
Evy Smyth (Salt Lake County) 1-801-493-4008
Fax 1-801-486-6721 Beeper 914-2082
Kathy Heffron (Salt Lake County) . . . 1-801-501-2181
Fax 1-801-501-2154 Beeper 914-6184
Harmony Greenberg (Utah County) . 1-801-426-1824
Fax 1-801-762-0089 Beeper 914-1109

Pregnant women living in Weber, Davis and Utah counties may receive care coordination through the local health department Baby Your Baby Program. Pregnant women living in Salt Lake County may receive care coordination through the Division of Community and Family Health Services Baby Your Baby Care Coordination Program. Contact one of the following numbers to refer IHC Access enrollees for care coordination:

Weber/ Morgan Health Department 801-778-6150
Davis County Health Department 801-451-3340
Division of Community and Family Health Services:
1-800-826-9662
Utah County Health Department , Lenora Siggard:
370-8733 FAX 343-8725

For more information, or if you have questions, please contact Julie Olson, Director, Bureau of Managed Health Care. E-mail: julieolson@utah.gov ☐

03 - 08 Client Notices

In December 2002, a notice was issued to clients about the reductions in Medicaid program services. Another notice was issued in early March about maintaining the Medicaid income limit for disabled people and seniors at 100% of the federal poverty rate. The web site for Medicaid client notices is:

http://health.utah.gov/medicaid/html/clients.htm

Look under the heading Client Notice for links to individual notices. ☐

03 - 09 Medical Supplies: HCPCS and Other Changes

Code A4670, Automatic blood pressure monitor for dialysis, is no longer a rental item, but is available for purchase only.

Code E0260, hospital bed, semi electric, with side rails has been opened as of January 1, 2003. This will the be reimbursed at the same rate as E0250, hospital bed, manual, side rails, both as a purchase and as a rental.

Discontinued or Closed Codes with Their Replacements

Y0406, Ostomy Pouch, extended wear, and Y0407, Ostomy, extended wear is replaced with

K0591, Ostomy Pouch, Urinary , with extended wear barrier attached , with facet-type tap with valve, each.

A4386, Ostomy Skin barrier, is replaced with

A4407, Ostomy skin barrier, with flange (solid, Flexible, or accordion, extended wear, with built-in convexity, 4x4 inches or smaller, each

Y0585, Filter, is replaced with

A7039, Filter, non disposable, used with positive airway pressure device and

A7038, Filter, disposable, used with positive airway pressure device.

Y0587, CPAP, tubing, is replaced with

A7037, tubing used with positive airway pressure device.

Y0581, CPAP headgear, is replaced with

A7035, headgear used with positive airway pressure device.

Y0586, BiPAP mask, is replaced with

A7030, full face mask use with positive airway pressure device, each and

A7034, Nasal interface (mask or cannula type) used with positive airway pressure devide, with or without head strap.

Y0440, Thick and Easy, per 8 ounces, is replaced with

B4100, Food thickener, administered orally per ounce.

S8105, Oximeter, is replaced with

E0445, Oximeter device for measuring blood oxygen levels non-invasively.

Y9088, Jobst garment, is replaced with

A6510, Compression burn garment, trunk, including arms down to leg openings, custom fabricated.

Y6060, Y6061, Y6062, Y6057, Y6058, Y6059, Y6092, diaper codes are closed and replaced with

A4521, Adult-sized incontinence diaper, small size, each.

A4522, Adult-sized incontinence diaper, medium size, each.

A4523, Adult-sized incontinence diaper, large size, each.

A4524, Adult-sized incontinence diaper, extra large size, each.

A4529, Child-sized incontinence diaper, small/medium size, each.

A4530, Child-sized incontinence diaper, large size, each.

A4533, Youth-sized incontinence diaper, each.

A4535, Disposable liner/shield for incontinence, each.

Y6051, In line suction catheter, not regular suction catheter is replaced with

A4610, Tracheal suction catheter, closed system, for 72 or more hours of use, each.

Y0384, Gloves, is replaced with

A4930, Gloves, sterile per pair.

Y0551, contour U back and seat, Y6135, GS back cushion (Jay), Y Contour U back or seat hardware replaced with

E1013, Integrated seating system, contoured, for pediatric wheelchair

Y6006, Tilt in space wheelchair is replaced with

E1231, Wheelchair, Pediatric Size, Tilt-in-space, rigid adjustable, with seating

E1232, Wheelchair, Pediatric Size, Tilt-in-space, folding, adjustable, with seating

E1233, Wheelchair, Pediatric Size, Tilt-in-space, rigid, adjustable, without seating

E1234, Wheelchair, Pediatric Size, Tilt-in-space, folding, adjustable, without seating

L5662, Addition to lower extremity is replaced with

K0556, Addition lower extremity, below/above knee socket, with locking

Discontinued Codes

A4370, Skin barrier, paste, per oz
A4572, Rib Belt
A5123, Skin barrier with flange . . .
A6263, Gauze, elastic, . . .
A6264, Gauze, non-elastic . . .
A6265, Tape, all types . . .
A6405, Gauze, elastic, . . .
A6406, Gauze, non-elastic . . .
L0300, Thoracic-lumbar-sacral-orthosis (TLSO). . .
L0310, TLSO, flexible . . .
L0320, TLSO, anterior-posterior control . . .
L0330, TLSO, anterior-posterior-lateral control . . .
L0370, TLSO, anterior-posterior-lateral-rotary control hyperextension . . .
L0390, TLSO, anterior-posterior-lateral control . . .
L5664, Addition to lower extremity . . .
E1091, Youth wheelchair, any type

Closed codes

Y0387, Sani-pants, per pair
Y0310, Incontinency clamp, Male only
Y6063, 3-way 30 cc balloon, non-allergic, special coating for continuous irrigation.
Y0407, Ostomy bag reusable/convatec/includes all supplies.
Y9072, Bags/enteral
Y6082, Specialized Walker including all attachments/gait trained.
Y6016, Chaston Gauze conforming
Y6015LR, Oximeter (per week)
Y0450, Aero chamber
Y0567, Wheelchair battery, UL lead acid
Y0569, Wheelchair battery, U1 gel
Y0376, Molded leather calf support for short or long leg brace
Y1499, Lymphedema sleeve and gauntlet
Y0363, Eye, artificial, rebuilding

Opened codes

Z6006, IV set, include tubing, needle, antiseptic and glove
E0260LR, Hospital Bed, semi electric with any type side rails and mattress
K0268LR, Humidifier, non-heated, used with positive airway pressure.
K0002LR, Standard Hemi (low seat) wheelchair
K0003LR, Lightweight wheelchair
K0004LR, High Strength, lightweight wheelchair
K0007LR, Extra heavy duty wheelchair
K0065, Spoke protector, each
K0108, Wheelchair component or accessory
L5420, Immediate post surgical or early fitting
L5450, Immediate post surgical or early fitting, below knee
L5671, Addition to lower extremity, below knee locking mechanism
Y5000, Kilogram scale (rental)
E0601LR, Nasal continuous airway pressure (CPAP) device. . .
A4624, tracheal suction catheter, . . .
A7031, Face mask interface, replacement for full face mask, each . . .
Hearing Aid codes added: V5130, V5140, V5242, V5243, V5248, V5249, V5050, V5254, V5255, V5256, V5257, V5060, V5266, V5266

Limits Changed

Codes listed below have a change in prior authorization criteria or limits on the April 2003 Medical Supplies List.
A4927.Gloves, non-sterile
A4352, Intermittent urinary catheter
A4580, Cast supplies . . .
E0202LR, Phototherapy (bilirubin) light . . .
Y5555, Enuresis Alarm
B4086, Gastrostomy / jejunostomy tube
E0776, I.V. pole
Y9216, Phenyl aid drink mix
Y9236, Periflex, 454 grams, for PKU
Y9243, Complete amino acid module 200 grams
A4231, Infusion set for external insulin pump
E0130, E0135, E0141, E0145, Walker(s) . . .
E0163, E0164, E0165, Commode chair(s) . . .
E0250,Hospital bed, and E0305, E0310,Bed side rails .
K0549LR, Hospital bed, heavy duty
E0424LR,Stationary compressed gaseous oxygen system . . .
E0431LR, Portable gaseous oxygen system . . .
E0439LRStationary liquid oxygen system . . .
E0434LR, Portable liquid oxygen system . . .
E0450LR, Volume ventilator
Y6020LR, Oxygen analyzer
Y6050LR Oxygen concentrator,
Y6065, Y6605LR, Y6610LR
Y6071, Overnight reading/oximeter . . .
E0565, Compressor, E0570, E0574LR, E0575, E0580, E0585LR, E0580, Y6030LR, Y6035LR . . .
E0600, Respiratory suction pump
PATIENT LIFTS and TRACTION EQUIPMENT:E0630, E0840LR, E0860LR, E0870, E0890, E0910, E0920LR, E0935LR
PNEUMATIC COMPRESSOR and APPLIANCES, limits clarified on E0651LR, E0652LR, E0667, E0668, E0671, E0672
Y0381, Hearing aid batteries

E0618, and E0619, Apnea monitor, are covered under contract only. They may not be billed directly to Medicaid.

Descriptors Updated by HCPCS 2003

A4388, A5051, A5052, A5054, A5062, A5063, A5072, A5073, E0574, K0082, K0083, K0085, L0500, L0510, L4350

Instructions for the Medical Supplies List

The Instructions for the Medical Supplies List, page 2, are updated to change the reference to "nursing home" (NH) to long term care facility (LTC) instead. The column heading, formerly **NH**, is now **LTC**. The explanation is changed to read "Indicates coverage for a resident of a long term care facility." ☐

03 - 10 Child Health Evaluation and Care Manual: Lead Toxicity Screening Assessment Updated

SECTION 2 of the Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services, Chapter 2 - 5, Appropriate Laboratory Tests, Item 5. Lead Toxicity Screening, sub-item A, Verbal Risk Assessment, has been updated. The revised SECTION 2 and Recommended Schedules are on the Internet. Look for the link to the CHEC manual at:

http://health.utah.gov/medicaid/section2list.pdf

In the updated manual, a page which states "Page updated April 2003" on the upper right of the page has a correction. A vertical line in the left margin marks where text has changed. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC manual, or use the Publication Request Form. ☐

03 - 11 Speech and Language Services: Speech Augmentative Communication Device (SACD) Reimbursement

SACD reimbursement is manually priced by Medicaid reviewers at 75% of the manufacturer's published price not to exceed 85% of the Medicare allowable for Utah which is $5724.00 as of 10/01/02.

The following codes are open as of April 1, 2003, to physicians and qualified audiologists for evaluation and training for patient use of SACD devices:

92607 Evaluation for Speech-Generation and Alternate Communication device, 1 hour
92608 Evaluation for Speech-Generation and Alternate Communication device, additional 30 minutes
92609 Therapy services for use of Speech-Generation device

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03 - 12 Vision Program Reductions

Beginning January 15, 2003, vision services for eye glass examinations and eye glasses are **not** covered for non-pregnant adults age 21 and older, who have traditional Medicaid. Examinations and treatment for medical problems, such as diabetic neuropathy, glaucoma, and cataracts are continued in the medical program using CPT codes. ☐

03 - 13 Neonatal and Pediatric Critical Care Services

Effective January 1, 2003, some significant changes were made in the CPT codes for Neonatal and Pediatric Critical Care Services including:

- Introduction of codes 99293 and 99294 as new pediatric critical care codes
- Discontinuation of 99297 as a neonatal critical care code
- Redefinition of code 99296 to be used to bill for subsequent care for both stable and unstable neonates requiring critical care
- Redefinition of code 99298 from neonatal critical care to neonatal intensive care for service to the infant with body weight less than 1500 grams.
- Introduction of 99299 as a new neonatal intensive care code for service to the infant with body weight between 1500 and 2500 grams

These Neonatal and Pediatric Critical Care Codes are bundled (global) codes to be:

- used only to bill for care required by neonates/infants between birth and 24 months of age who require critical care or intensive care services
- billed only once for each 24-hour period
- inclusive of a broad range of services rendered by all physicians involved in the health care team which provides continuous management and care for the infant/child during the 24-hour period

Provision of services and coding is selectively limited to Board Certified Neonatologists, Board Certified Pediatric Intensivists, High Risk Pediatricians or Board Certified Pediatricians depending on the level of care required. Board Certified neonatologists, Board Certified Pediatric Intensivists, and Board Certified Pediatricians who meet the qualifications and are not currently enrolled to provide service under this program should contact Medicaid Provider Enrollment at 1-800-662-9651 prior to submitting any billings. Policy is added to the Physician Manual, SECTION 2, Covered Services, Item #32, and Limitations Item #JJ. Current items #32 and 33 are renumbered. ☐

03 - 14 Diagnostic and Rehabilitative Mental Health Services by DHS Contractors: Major Manual Revision

Effective April 03, the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors has undergone a major revision. Please review the entire manual. A copy of SECTION 2 has been sent under separate cover to Medicaid providers enrolled to provide services under this program. If you are a contractor and do not receive a copy, please contact Medicaid Information. ☐

03 - 15 Targeted Case Management for CHEC Medicaid Eligible Children: Major Manual Revision

Effective April 03, the Utah Medicaid Provider Manual for Targeted Case Management for CHEC Medicaid Eligible Children has undergone a major revision. Please review the entire manual. ☐

03 - 16 Assistant Surgeon Modifier NOT Authorized on Global Obstetrical Codes

Global, routine Obstetric Care Codes - 59400, 59510, 59610, 59618 are not authorized for use of modifier 80 - Assistant Surgeon. There is no surgery or other "assistant" services involved in routine prenatal care and normal delivery. An assistant surgeon is authorized for a cesarean section delivery. The physician who assists on a cesarean section delivery should use code 59514 or 59620 - Cesarean delivery only - with the addition of the 80 modifier. This coding combination appropriately shows the service provided and will result in the appropriate payment to the assistant surgeon. Assistant surgeon services are limited only to physicians. These codes have been added to the list of CPT Procedure Codes NOT Authorized for An Assistant Surgeon which is found in the Physician Provider manual. ☐

03 - 17 Codes NOT Authorized for an Assistant Surgeon

The list Codes NOT Authorized for An Assistant Surgeon in the Utah Medicaid Provider Manual for Physician Services has been updated as a result of HCPCS 2003. (Codes on this list may be covered by Medicaid but are NOT covered for an assistant surgeon.) Discontinued codes are removed, and new codes are added. Providers of physician services will find a new list attached. For more information regarding the effective dates of revisions, refer to Bulletin 03 - 05, Health Common Procedure Coding System - 2003 Revisions.

Codes Discontinued

The CPT codes which follow are removed from the list because they are discontinued: 21041, 36415, 36520, 36521, 53670, 53675, 58551, 61790, 61791, 61795, 62263.

Codes Added to List "NOT Authorized for An Assistant Surgeon"

The following codes are NOT covered for an assistant surgeon and have been added to the list:

20612	36513	49904	61316
21046	36514	51703	64447
21047	36515	56820	66990
21048	36516	56821	76496
21049	37501	57420	76801
29827	38206	57421	76802
29873	38210	57455	76805
29899	38211	57456	76810
33215	38212	57461	76811
33224	38213	59400	76812
33225	38214	59409	76815
33226	38215	59510	76816
35572	38242	59409	76817
36416	44239	59510	84302
36511	44701	59610	92612
36512	45340	59618	92614

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03 - 18 Dental Program: Coding Changes

Beginning April 1, 2003 the following changes are implemented. Please make these coding changes immediately. Billing with discontinued codes will result in denial of reimbursement after April 1st. Offices will need to especially be aware of the amalgam and composite resin filling coding changes which will greatly affect the billing procedures with Medicaid.

The following dental codes have been closed for use in the Medicaid Dental Program.

D5710 Rebase complete upper denture
D5711 Rebase complete lower denture
D7880 Occlusal orthotic appliance
Y0511 Orthodontic payout
Y0513 Regional consultation
Y5999 Extraction non-infected tooth prior to orthodontia

The following dental code changes are in accordance with the new ADA coding guidelines.

Amalgam and Composite fillings

The following codes are discontinued:

D2110, Amalgam - one surface, primary
D2121, Amalgam - two surfaces, primary
D2130, Amalgam - three surfaces, primary
D2131, Amalgam - four surfaces, primary
D2380, Composite resin- one surface posterior, primary teeth
D2385, Composite resin- one surface posterior permanent teeth

They are replaced with:

D2140, Amalgam - one surface, primary or permanent
D2150, Amalgam - two surfaces, primary or permanent
D2160, Amalgam - three surfaces, primary or permanent
D2161, Amalgam - four or more surfaces, primary or permanent
D2391, Resin-based composite - one surface, posterior, primary or permanent

Extractions

The following codes have been discontinued:

D7110, Extraction, single tooth
D7120, Extraction, each additional tooth, at the same visit
D7130, Root removal - exposed roots

They are replaced by:

D7140, Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7111, Coronal remnants - Deciduous tooth

Surgical Procedures

The following codes have been discontinued:

D7430, Excision, benign tumor, diameter up to 1.25 cm

It is replaced with:

D7410, Excision, benign tumor, diameter up to 1.25 cm (note descriptor change)

Anesthesia

The following codes have a significant descriptor change:

D9241, Intravenous conscious sedation/analgesia - first 30 minutes all ages, by oral surgeons in an office setting
D9242, Intravenous conscious sedation/analgesia - each additional 15 minutes
D9220, Deep sedation - general anesthesia first 30 minutes, in office

□

03 - 19 Oral Surgery Code Changes

Discontinued codes with their replacement codes:

D7110, Extraction, single tooth, and D7120, Extraction, each additional tooth, and D7130, Root removal-exposed roots are replaced with D7140, Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7440, Excision of Malignant lesion is replaced with D7413, Excision of Malignant lesion up to 1.25 CM

D7441, Excision of Malignant lesion is replaced with D7414, Excision of Malignant lesion greater than 1.25 CM

Discontinued codes:

D7420, Radical excision-lesion diameter grater than 1.25 CM

D7430, Excision of benign tumor-lesion diameter up to 1.25 CM

D7431,Excision of benign tumor-lesion diameter greater than 1.25 CM

21041 Excision of benign cyst or tumor of mandible; complex

Added codes:

D7411, Excision of Benign lesion greater than 1.25 CM

D7412, Excision of Benign lesion, complicated

Additional descriptor changes: 21030, 21040

□

03 - 20 Physical and Occupational Therapy

Beginning January 15, 2003, physical therapy and occupational therapy services are **not** covered for non-pregnant adults age 21 and older through traditional stand alone or contracted physical or occupational therapy clinics or individual physical or occupational therapy providers. There remains a provision for physical and occupational therapy covered through out patient hospital services which are a part of the hospital and billed using revenue codes on a UB92 form. This removes coverage through home health services. ☐

03 - 21 Psychology Services: CHEC Eligibles Defined; Limit on Use of Coercive Techniques

The Psychology Services Provider Manual has been updated to revise the definitions of CHEC, Medicaid's Children's Health Evaluation and Care program. Under the revised definition, Medicaid recipients age 19 and older enrolled in the Non-Traditional Medicaid Plan are not eligible for CHEC services and therefore, are not eligible for services under the Medicaid psychology program.

The manual has also been updated to revise the limitation on use of coercive techniques. Psychology providers will find attached updated pages to update their provider manuals. On pages dated April 2003, a vertical line in the left margin marks where text has been changed. Any questions, contact Merrila Erickson at (801) 538-6501. ☐

03 - 22 Health Common Procedure Coding System - 2003 Revisions

Effective for dates of services on or after January 1, 2003, Medicaid began accepting the 2003 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2003 Physicians' Current Procedural Terminology (CPT) codes.

Other articles in this April 2003 Medicaid Information Bulletin contain details about coding changes for services by physicians, medical suppliers and so forth. Any 2002 HCPCS codes discontinued in 2003 may be used for dates of services prior to April 1, 2003. For services on and after April 1, 2003, providers must use the 2003 HCPCS codes. If you have a question about billing the 2003 HCPCS codes, contact Medicaid Information. ☐

03 - 23 CPT Code Changes

The Medical and Surgical Procedures List in the Utah Medicaid Provider Manual for Physician Services has been updated in accordance with Year 2003 Current Procedural Terminology (CPT) codes. The list includes codes which are not covered by Medicaid, or require prior authorization, or have other limitations. This bulletin summarizes the changes to the list. HCPCS descriptors, abbreviated in this bulletin, are stated in full on the Medicaid list.

For more information on the effective dates of this year's revisions, refer to Bulletin 03 - 22, Health Common Procedure Coding System - 2003 Revisions.

CPT Codes Not Covered

Medicaid does not cover the CPT codes listed below. The Medicaid list states these codes are "NOT A BENEFIT." Descriptors in the list below are abbreviated.

00640 Anesthesia for manipulation of the spine
15810 Salabrasion, 20 sq cm or less
01991 Anesthesia for Dx or Rx nerve block injections
01992 Anesthesia for Dx or Rx nerve block injections
21742 Reconstructive repair of pectus excavatum
21743 Reconstructive repair of pectus excavatum
21188 Reconstruction midface, osteotomies
33508 Endoscopy, surgical, including video-assisted
33970 Insertion of intra-aortic balloon assist device
33971 Removal of intra-aortic balloon assist device
33973 Insertion of intra-aortic balloon device
33974 Removal of intra-aortic balloon assist device
34833 Open iliac artery exposure with creation
34834 Open iliac artery exposure to assist ...
34900 Endovascular graft replacement repair iliac artery
36415 Venipuncture, routine (removed heel/fingerstick)
36522 Photopheresis, extracoporeal
36536 Mechanical removal of pericatheter obstructive
36537 Mechanical removal of intraluminal obstructive
37182 Insert transvenous intrahepatic portosystemic shunt (TIPS)
37183 Revise transvenous intrahepatic portosystemic shunt (TIPS)
37500 Vascular endoscopy, surgical w ligation of perforator veins
38204 Management recipient hematopoietic progenitor cell, donor
38205 Hematopoietic progenitor cell harvesting, allogenic
38207 Transplant preparation of hematopoietic

progenitor cells;
38208 Thawing of previous frozen harvest
38209 Washing of harvest
43201 Esophagoscopy rigid or flexible
43236 Uppergastrointestinal endoscopy w submucosal injection
44206 Laparoscopy, surgical; colectomy, partial with end colostomy
44207 . . . .colectomy, partial anastomosis, coloproctostomy
44208 . . . .colectomy, partial anastomosis, coloproctostomy/colostomy
44210 . . . .colectomy, total abd. w/o proctectomy w illeostomy/ileoproto...
44211 . . . .colectomy, total abd. w/o proctectomy w illeoanal anastomosis
44212 . . . .colectomy, total abd. w proctectomy w loop ileostomy
44238 Unlisted laparoscopy procedure, intestine (except rectum)
44701 Intraoperative colonic lavage
45335 Sigmoidoscopy, flexible, with directed submucosal injection
45381 Colonoscopy, flexible, with directed submucosal injection
45386 . . . .with dilation - balloon one or more strictures
46706 Repair of anal fistula with fibrin glue
49419 Insertion intraperitoneal cannula or catheter, w reservoir
49905 . . . . omental flap, intra-abdominal
50542 Laparoscopy, surg. ablation of renal mass lesions
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61517 Implantation of brain intracavity chemotherapy
61623 Endovascular temp. balloon arterial occlusion, head/neck
61711 Anastomosis, arterial, extracranial-intracranial
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61735 Creation lesion by stereotactic method
61760 Stereotactic implantation of depth electrodes
61790 Creation of lesion by stereotactic method, RF...
61791 Creation of lesion ...; trigeminal medullary tract
61793 Stereotactic radiosurgery; one or more sessions
61795 Stereotactic computer assisted volumetric
61862 Twists drill burr hole, craniotomy, or craniectomy
62148 Incision and retrieval of subcutaneous cranial bone graft
62160 Neuroendoscopy, intracranial placement/replace ventricular catheter
62161 Neuroendoscopy, intracranial; for dissection of adhesions
62162 . . . .with fenestration or excision of colloid cysts
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62201 Ventriculocisternostomy, 3rd ventricle neuroendoscopic method is not covered.
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64416 . . . . brachial plexus, continuous infusion by catheter
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72275 Epidurography, radiological supervision . . .
73542 Radiological examination, sacroilliac joint arthrography, radiological supervision ...
73720 MRI lower extremity, other than joint
74740 Hysterosalpingography, radiological supervision
74742 Transcervical catheterization of fallopian tube
75556 Cardiac magnetic resonance imaging for velocity flow mapping
75809 Shuntogram for investigation of previously placed indwelling nonvascular shunt
75900 Exchange of previously placed arterial catheter
75901 Mechanical removal of pericatheter obstructive material
75902 Mechanical removal of intraluminal obstructive material
75945 Intravascular ultrasound (non-coronary vessel)
75946 . . . each additional
75954 Endovascular repair of iliac artery aneurysm ...
75960 Transcatheter introduction of intravascular stent(s) non-coronary vessel
75992 Transluminal atherectomy, peripheral artery
75993 Transluminal atherectomy, each additional
75994 Transluminal atherectomy, renal
75995 Transluminal atherectomy, visceral
75996 Transluminal atherectomy, each additional
76005 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous
76071 CT, appendicular skeleton (peripheral)
76390 Magnetic Resonance Spectroscopy

76497 Unlisted CT procedure (i.e. diagnostic or interventional)
76498 Unlisted magnetic resonance procedure
76827 Doppler echocardiography, fetal, cardiovascular
76828 . . . follow-up or repeat study
76873 . . . prostate volume study for brachytherapy
76930 Ultrasound guidance for pericardiocentesis
76932 Ultrasound guidance for endomyocardial biopsy
78206 . . . with vascular flow
78267 Urea breath test, C-14; acquisition and analysis
78268 . . . analysis
80102 Drug confirmation, each procedure
80103 Tissue preparation for drug analysis
83880 Natriuretic peptide
85380 Fibrin degradation products, D-Dimer
86911 . . . each additional antigen system
87255 Virus isolation; ... other than by cytopathic effect
87267 Infectious agent antigen detection ... enterovirus (DFA)
87271 Infectious agent antigen detection ... cytomegalovirus,(DFA)
88125 Cytopathology, forensic
88174 Cytopathology, cervical/vaginal by automated system
88175 Cytopathology, cervical/vaginal, automated & manual rescreen
88321 Consultation and report on referred slides
88323 Consultation and report on referred material
88325 Consultation, comprehensive
88380 Microdissection (eg, mechanical, laser capture)
89055 Leukocyte count, fecal
89250 Culture and fertilization of oocyte(s)
89300 Semen analysis; presence and/or motility
89310 . . . motility and count (not Huhner test)
89320 . . . complete (volume, count, motility and diff.)
89325 Sperm antibodies
89329 Sperm evaluation; hamster penetration test
89330 . . . cervical mucous penetration test
90476 Adenovirus vaccine, live for oral use
90477 Adenovirus, type 7, live for oral use
90581 Anthrax vaccine, for subcutaneous use
90660 Influenza vaccine, live, for intranasal use
90669 Pneumococcal conjugate vaccine, polyvalent
90680 Rotavirus vaccine, tetravalent, live for oral use
90692 Typhoid vaccine, heat- and phenol-inactivated
90693 Typhoid vaccine, acetone killed, dried (AKD)
92358 Prosthesis service for aphakia, temporary
92370 Repair and refitting spectacles; except aphakia
92371 . . . spectacle prosthesis for aphakia
92579 Visual reinforcement audiometry (VRA)
92586 . . . limited
92587 Evoked otoacoustic emissions; limited
92588 . . . comprehensive or diagnostic evaluation
92601 Diagnostic analysis of cochlear implant, patient under 7 years of age with programming
92602 Diagnostic analysis of cochlear implant, patient under 7 years of age with subsequent programming
92603 Diagnostic analysis of cochlear implant, 7 years of age or older, with programming
92604 Diagnostic analysis of cochlear implant, 7 years of age or older, with subsequent programming
92605 Eval. for Rx of non-speech generating device
92606 Therapeutic services for the use of non-speech generating device
92614 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine/video recording
92615 . . . . physician interpretation and report only
92616 Flexible fiberoptic endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording
92617 . . . . physician interpretation and report only
93314 . . . image acquistion, interpretation and report
93571 Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement
93572 . . . each additional vessel
93580 Percutaneous transcatheter closure congenital interatrial defect
93581 Percutaneous transcatheter closure congenital ventricular septal defect
93668 Peripheral arterial disease (PAD) rehabilitation
93733 Electronic analysis of antitachycardia pacemaker system
93736 Electronic analysis of single chamber internal pacemaker system
93784 Ambulatory blood pressure monitoring
93797 Physician services for outpatient cardiac rehab.
93798 . . . with continous ECG monitoring
93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981 . . . followup or limited study
94016 . . . physician review and interpretation only
94664 Demonstration or evaluation of patient utilization of an aerosol generator, nebulizer, metered
95805 Multiple step latency or maintenance of wakefulness testing
95806 Sleep study, simultaneous recording ventilation
96920 Laser treatment inflammatory skin disease (psoriasis); <250 sq cm
96921 Laser treatment inflammatory skin disease (psoriasis); 250-500 sq cm
96922 Laser treatment for inflammatory skin disease (psoriasis); > 500 sq cm
97150 Therapeutic procedure(s) group
97532 Development of cognitive skills to improve attention, memory, problem solving ...
97533 Sensory integrative techniques to enhance

sensory processing -promote adaptive response
99000 Handling and/or conveyance of specimen for transfer from physician's office to the laboratory
99001 Handling . . . specimen for transfer from the patient in other than physician's office
99002 Handling ... any other service in connection with implementation of an order involving devices
99024 Postoperative followup visit, included in global
99026 Hospital mandated on call service; in-hospital,
99027 Hospital mandated on call service; out of hospital, each hour
99173 Screening test of visual acuity, quantitative, bil
99239 Hospital discharge day management > 30 min.
99288 Physician direction -emergency medical service
99341 Home visit, evaluation & management, new patient
99342 Home visit for E&M of new patient
99343 Home visit for E&M of new patient
99386 . . . 40-64 years
99387 . . . 65 years and over
99396 . . . 40-64 years
99397 . . . 65 years and over
99600 Unlisted home visit service or procedure

CPT Codes Which Have Been Closed or Discontinued

The following codes are discontinued and have been removed from the Medicaid list:

28735 Arthodesis midtarsal/tarsometatarsal
00869, 21041, 36520, 36521, 38231, 44209, 53670, 53675, 58551, 80090, 85021, 85022, 85023, 85024, 85031, 85585, 85590, 85595, 86915, 88144, 88145, 90700, 92525, 92598, 92599, 94650, 94651, 94652, 94665, 99297, 99508, 99539.

"S" and "G" codes

S and G codes are Medicare codes. "S" codes are temporary National Codes for Private Payer use and may be become permanently used by Medicaid. Comparable CPT codes are available and may be used by Medicaid. "S" and "G" codes are covered only when submitted as a crossover claim. The following G codes are **not** covered by Medicaid even for crossover patients:

G0202 Screening mammography, direct digital image, bilateral
G0204 Diagnostic mammography, direct digital image, billateral
G0206 Diagnostic mammography, direct digital image, unilateral
G0252 PET imaging ... for initial diagnosis of breast cancer, surgical planning
G0253 PET imaging ... for staging/ restaging of recurrence or distant metastases
G0254 PET imaging for breast cancer, evaluation of response to treatment
G0264 Initial nursing assessment of patient directly admitted to observation
G0265 Cryopreservation, freezing and storage of cells for therapeutic use
G0266 Thawing and expansion of frozen cells for therapeutic use
G0267 Bone marrow or peripheral stem cell harvest, modification or treatment
G0268 Removal impacted cerumen by physician
G0270 Medical nutrition therapy, reassessment and subsequent interventions
G0271 Medical nutrition therapy reassessment following 2nd referral
G0272 Naso/oro gastric tube placement, requiring physician skill
G0273 Radiopharmaceutical biodistribution, single or multiple scans
G0274 Radiopharmaceutical therapy, non-hodgkins lymphoma
G0275 Renal arter angiography (uni- or bilateral) at time of cardiac cath
G0278 Iliac artery angiography performed at the time of cardiac cath
G0279 Extracorporeal chock wave therapy, involving elbow epidondylitis
G0280 Extracorporeal shock wave therapy, involving other than elbow
G0281 Electrical stimulation, ... for chronic pressure ulcers
G0282 Electrical stimulation, ... for wound care
G0283 Electrical stimulation, ...other than wound as therapy plan
G0288 Reconstruction, CT angio of aorta
G0289 Arthroscopy knee for FB, debridement
G0290 Transcatheter place drug eluting intracoronary stent, single
G0291 Transcatheter place drug eluting intracoronary stent, each add
G0292 Admnistration of experimental drug in a Medicare qualifying clinical trial
G0293 Noncovered surgical procedure using conscious sedation ... clinical trial
G0294 Noncovered procedure using none or local anesthesia ... clinical trial
G0295 Electromagnetic stimulation to one or more areas

CPT Codes Requiring Prior Authorization

The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the list dated April 2003.

Telephone Prior Approval Required for Codes Listed below

00921 Anesthesia on male genitalia; vasectomy uni or bilateral Refer to criteria #10
29807 . . . repair of slap lesion Refer to Criteria #4
29827 . . . with rotator cuff repair Refer to Criteria #4
29873 Arthroscopy, knee surgical; with lateral release Refer to Criteria #4
29899 Arthroscopy, ankle, (tibiotalar and fibulotalar joints) Refer to Criteria #4
58146 . . . .excision of fibroid tumors of uterus, ≥ 5 Refer to Criteria #12
58290 Vaginal hysterectomy for uterus greater than 250 grams Refer to Criteria #15
58291 . . . with removal of tubes and ovaries Refer to Criteria #15
58292 . . . with removal of tubes , ovaries, and repair enterocele Refer to Criteria #15
58293 . . . with colpo-urethrocystopexyra type Refer to Criteria #15
58294 . . . with repair of enterocele Refer to Criteria #15
58545 Lap. myomectomy; 1 to 4 intramural myomas; wt. ≤ 250 gms, Refer to Criteria #12
58546 . . . ≥5 intramural myomas ; total wt. greater than 250 gms, Refer to Criteria #12
58552 . . . with removal of tubes and ovaries Refer to Criteria #15
58553 Lap. with vaginal hysterectomy for uterus > 250 grams Refer to Criteria #15
58554 . . . with removal of tubes and ovaries Refer to Criteria #15
76805 Ultrasound pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester
76810 . . . . each additional gestation
76811 Ultrasound, pregnant uterus, fetal & maternal evaluation Refer to criteria #39
76812 . . . . each additional gestation Refer to criteria #39
76815 Ultrasound, pregnant uterus, limited Refer to criteria #39
76816 Ultrasound, pregnant uterus, follow-up Refer to criteria #39
76817 Ultrasound, pregnant uterus, transvaginal Refer to criteria #39
99349 Home visit for evaluation and management of an established patient. LIMITED to Hospice and special care situations

Written Prior Approval Required for Codes Listed below

22842 Posterior segmental instrumentation, 3-6 vertebral segment Refer to criteria #2
38206 Hematopoietic progenitor cell harvesting, autologous Refer to criteria #25
38210 Specific cell depletion within harvest, T-cell depletion Refer to criteria #25
38211 Tumor cell depletion Refer to criteria #25
38212 Red blood cell depletion removal Refer to criteria #25
38213 Platelet depletion removal Refer to criteria #25
38214 Plasma volume depletion Refer to criteria #25
38215 Cell concentration plasma, mononuclear, buffy coat Refer to criteria #25
38242 Allogenic donor lymphocyte infusions Refer to criteria #25
63650 Percutaneous implantation of neurostimulator, epidural Refer to criteria #32C
63655 Laminectomy for implantation of neurostimulator Refer to criteria #32C
64561 Percutaneous implant neurostimulator electrode; sacral Refer to criteria #32B
64573 Incision/implantation neurostimulator electrodes; cranial nerve Refer to Criteria #32A
64581 Incision for neurostimulator electrode implant; sacral Refer to criteria #32B
72141 MRI spinal canal and contents, cervical w/o contrast Refer to criteria #40B
72142 MRI spinal canal and contents, cervical with contrast Refer to criteria #40B
72146 MRI spinal canal and contents, thoracic w/o contrast Refer to criteria #40B
72147 MRI spinal canal and contents, thoracic with contrast Refer to criteria #40B
72148 MRI spinal canal and contents, lumbar w/o contrast Refer to criteria #40B
72149 MRI spinal canal and contents, lumbar with contrast Refer to criteria #40B
72156 MRI spinal canal and contents, cervical w/o w contrast Refer to criteria #40B
72157 MRI spinal canal and contents, thoracic w/o w contrast Refer to criteria #40B
72158 MRI spinal canal and contents, lumbar w/o w contrast Refer to criteria #40B

Codes Limited by Age

The following new CPT Codes are limited by age:

Covered for children less than twenty-one years of age

73720 MRI lower extremity, other than joint
92607 Evaluation for prescription for speech generating augmentative and alternative communication device
92608 Evaluation for prescription for speech ...; each additional 30 minutes
92609 Therapeutic services for the use of speech-

generating device, including programming and modification. Written PA required.

Covered for children less than one year of age

00326 Anesthesia for all procedures on larynx and trachea in children less than 1 year of age
00834 Anesthesia for hernia repairs in the lower abdomen not otherwise specified, under 1 year of age
00836 Anesthesia for repair lower abdomen, NOS, less than 4 months gestational age at surgery
36416 Collection of capillary blood specimen (finger or heel stick)

Covered for children more than one year of age

00320 Anesthesia for all procedures of neck not otherwise specified ; age one or older

CPT Code Requiring Documentation with Claim

An unlisted CPT code and the following codes do not require prior authorization. However, it the provider must attach documentation to the claim for physician review.

01924 Anesthesia for therapeutic interventional radiological procedures ... arterial system
01930 Anesthesia for therapeutic interventional radiologic procedures ... venous/lymphatic system
01999 Unlisted anesthesia procedure
11400 Excision benign lesion ... trunk, arms, or legs; excised diameter 0.5 cm or less
11401 . . . . . excised diameter 0.6 to 1.0 cm
11402 . . . . . excised diameter 1.1 to 2.0 cm
11403 . . . . . excised diameter 2.1 to 3.0 cm
11404 . . . . . excised diameter 3.1 to 4.0 cm
11406 . . . . . .excised diameter over 4.0 cm
11420 Excision benign lesion ... scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 . . . . . excised diameter 0.6 to 1.0 cm
11422 . . . . . excised diameter 1.1 to 2.0 cm
11423 . . . . . excised diameter 2.1 to 3.0 cm
11424 . . . . . excised diameter 3.1 to 4.0 cm
11426 . . . . . .excised diameter over 4.0 cm
11440 Excision benign lesion ...face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441 . . . . . excised diameter 0.6 to 1.0 cm
11442 . . . . . excised diameter 1.1 to 2.0 cm
11443 . . . . . excised diameter 2.1 to 3.0 cm
11444 . . . . . excised diameter 3.1 to 4.0 cm
11446 . . . . . .excised diameter over 4.0 cm
33250 OR ablation supraventricular arrhythmogenic focus
33251 OR ablation of supraventricular arrhythmogenic focus with cardiopulmonary bypass
33261 OR ablation of ventricular arrhythmogenic focus
36511 Therapeutic apheresis; for white blood cells
36512 Therapeutic apheresis; for red blood cells
36513 Therapeutic apheresis; for platelets
36514 Therapeutic apheresis; for plasma pheresis
36515 Therapeutic apheresis w extracorporeal immunoadsorption
36516 Therapeutic apheresis w extracorporeal selective
37501 Unlisted vascular endoscopy procedure
44209 Unlisted laparoscopy procedure intestine
44239 Unlisted laparoscopy procedure, rectum
44701 Intraoperative colonic lavage
49000 Exploratory laparotomy, exploratory celiotomy
59898 Unlisted laparoscopy procedure, maternity care and delivery
60659 Unlisted laparoscopy procedure, endocrine
60699 Unlisted procedure, endocrine system
69990 Microsurgical technique,... operating microscope
62201 Ventriculocisternostomy, 3rd ventricle stereotactic method is covered, while neuroendoscopic method is not a benefit.
69990 Microsurgical technique requiring use of operating microscope
72195 Magnetic resonance imaging, pelvis; w/o contrast material
72196 . . . with contrast material
72197 . . . w/o contrast followed by contrast material
76499 Unlisted diagnosis radiographic procedure
76999 Unlisted ultrasound procedure
77299 Unlisted procedure, therapeutic radiology
77399 Unlisted procedure, medical radiation physics
77499 Unlisted procedure, therapeutic radiology treatment management
77799 Unlisted procedure, clinical bradytherapy
78099 Unlisted endocrine procedure, diagnostic
78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic
78299 Unlisted gastrointestinal procedure, diagnostic
78399 Unlisted musculoskeletal procedure, diagnostic
78499 Unlisted cardiovascular procedure, diagnostic
78599 Unlisted respiratory procedure, diagnostic
78699 Unlisted nervous system procedure, diagnostic
78799 Unlisted genitourinary procedure, diagnostic
78999 Unlisted miscellaneous procedure, diagnostic
79999 Unlisted radiopharmaceutical therapeutic procedure
80299 Quantitation of drug, not elsewhere specified
81099 Unlisted urinalysis procedure
84999 Unlisted chemistry profile
85999 Unlisted hematology and coagulation procedure
86849 Unlisted immunology procedure
86999 Unlisted transfusion medicine procedure
87300 Infectious agent antigen detection by immunofluorescent technique, polyvalent for multiple organisms, each polyvalent antiserum
87451 Infectious agent antigen detection by enzyme

immunoassay technique qualitative or semiquanitative; multiple step method, polyvalent for multiple organisms, each polyvalent antiserum
87999 Unlisted microbiology procedure
88199 Unlisted cytopathology procedure
88299 Unlisted cytogenetic study
88399 Unlisted surgical pathology procedure
90749 Unlisted vaccine/toxoid
92700 Unlisted otorhinolaryngological service or procedure
93650 Intracardiac catheter ablation of AV node function
93651 Intracardiac catheter ablation of arrythmogenic focus
93652 Intracardiac catheter ablation of arrythmogenic focus,. VT
93799 Unlisted cardiovascular service or procedure
94799 Unlisted pulmonary service or procedure
95199 Unlisted allergy/clinical immunologic service
97039 Unlisted modality (specify type, time ...)
97139 Unlisted therapeutic procedure (specify)
97799 Unlisted physical medicine/rehabilitation proc.
99199 Unlisted special service, procedure or report
99358 Prolonged evaluation and management service
99359 . . . each additional 30 minutes

CPT Codes With Other Criteria

Two other groups of CPT codes do not require prior authorization, but are subject to new Medicaid criteria.

Benign Lesions: Since there has been an increase in the number of lesions which appear to be removed for cosmetic reasons, CPT codes 11400 through 11446 which require surgical removal of benign lesions will now require submission of documentation for manual review under the Criteria for Benign Lesions. Physician Services Provider Manual, Criteria for Medical and Surgical Procedures, #34, page 33 - 34.

Ultrasound in Pregnancy: Prior authorization is not required for first date of service for the following codes but subsequent ultrasounds will require PA.

76801 Ultrasound pregnant uterus (<14 weeks); single or 1st gestation
76802 . . . . each additional gestation
76805 Ultrasound pregnant uterus (>14 weeks),single or 1st gestation
76810 . . . . each additional gestation

Imaging: CT & MRI: Since CT scans of the whole body and the chest, and MRI's of the whole body and spine were being completed for routine evaluation and/or screening purposes, a criterion was developed to clarify coverage policy. It is based on recommendation and research from other insurance plan coverage, Medicare, as well as local and national medical specialists. CT and MRI of the whole body are not covered services, including procedures billed under unlisted codes 76497 and 76498. Prior authorization is not required for Thoracic CT scans, however medical necessity must be met under Criteria #40A.

71250 Computed tomograpy, thorax; without contrast material
71260 . . . . with contrast material
71270 . . . .without contrast material followed by contrast material

Prior authorization is not required for MRI of the Spine, however medical necessity must be met under Criteria #40B.

72141 MRI, spinal canal and contents, cervical; w/o contrast
72142 ... with contrast material(s)
72146 MRI, spinal canal and contents, thoracic; w/o contrast
72147 ... with contrast material(s)
72148 MRI, spinal canal and contents, lumbar; w/o contrast
72149 ... with contrast
72156 MRI, spinal canal and contents, w/o contrast material followed contrast; cervical
72157 MRI, spinal canal and contents, w/o contrast material followed contrast; thoracic
72158 MRI, spinal canal and contents, w/o contrast material followed contrast; lumbar

Epidural Block Injections: The following CPT codes have been added to criteria for epidural block, Physician Services Provider Manual, Criteria for Medical and Surgical Procedures, #33B, page 31-32.

64402 anesthetic injection facial nerve
64415 anesthetic injection brachia plexus, single
64445 anesthetic injection sciatic nerve, single
64447 anesthetic injection femoral nerve, single

Fiberoptic endoscopic evaluation of swallowing: Prior authorization is not required, however services must meet medical necessity under criteria #41, Fiberoptic endoscopic evaluation of swallowing (FEESST)

31575 Laryngoscopy, flexible fiberoptic; diagnostic
92610 Evaluation of oral and pharyngeal swallowing function
92612 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording
92613 . . . . physician interpretation and report only
92520 Laryngeal function studies

Codes with Descriptor Changes

Descriptors for the following codes on the list have been corrected in accordance with HCPCS 2003: 00320, 01382, 01400, 01464, 01622, 01630, 01732, 01740, 01830, 01960, 01961, 01962, 01963, 01964, 01968, 01969, 01996, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 15756, 17304, 17310, 20550, 20552, 20553, 20600, 20605, 21030, 21034, 21040, 21740, 23410, 24516, 25320, 25430, 26440, 27235, 27244, 27425, 27730, 27759, 27870, 29540, 33216, 34812, 34825, 36415, 36540, 36830, 37140, 37760, 38220, 38221, 49200, 49905, 52001, 52354, 52355, 53440, 53442, 57452, 57454, 57460, 58140, 58260, 58550, 61340, 61624, 61751, 62201, 62263, 62284, 64415, 64445, 69424, 70450, 70480, 70490, 71250, 72125, 72128, 72131, 72192, 73200, 73700, 74022, 74150, 75953, 75989, 76006, 76070, 76085, 76355, 76360, 76370, 76380, 76499, 76805, 76810, 76815, 76816, 76999, 77326, 83015, 85007, 85008, 85009, 85014, 85018, 85025, 85027, 85041, 85044, 85045, 85048, 85378, 85576, 86930, 86931, 86932, 87207, 87254, 89310, 92597, 93012, 93268, 93620, 94640, 94664, 95027, 95812, 95816, 95819, 95822, 95827, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95875, 96530, 99100, 99504, 99551, 99552, 99553, 99554, 99555, 99556, 99557, 99558, 99559, 99560, 99561, 99562, 99563, 99564, 99565, 99566, 99567, 99568, 99569, 99289, 99295, 99296, 99298

Changes to Pediatric and Neonatal Code Descriptors

Two new codes 99293 and 99294 have been added for pediatric critical care in patients which may be used by board certified Neonatologists. Two codes, 99295 and 99296, are still available only to board certified Neonatologists. Subsequent intensive care code 99298 is open only to board certified neonatologists, board certified pediatric intensivists, and high risk pediatricians. Subsequent care code 99299 is open only to board certified neonatologists, board certified pediatric intensivists, board certified high risk pediatricians, or board certified pediatricians.

Medical and Surgical Procedures List Updated

Providers of physician services will find attached a Medical and Surgical Procedures List dated April 2003 to replace the old list. Some codes from prior years were inadvertently left off the list; these were added. New codes are in bold print. A vertical line in the margin marks where text was changed or added. An asterisk (*) marks where a code was deleted. For more information on effective dates, refer to Bulletin 03 - 22, Health Common Procedure Coding System - 2003 Revisions.

Hospital Surgical Procedures List Updated

The hospital manual was updated to include new 2003 CPT procedures on the Hospital Surgical Procedures list. There were some covered codes from prior years which were inadvertently left off the list. These codes were added to the list.

Materials and Supplies

The following code was opened up for physician's use in conjunction with office treatment beginning January 1, 2003.

A4565 Sling
A4580 Cast supplies (i.e. Plaster)
A4590 Special Casting Material (i.e. Fiberglass)
A6231 Gauze impregnated, hydrogel pad, size ≤ 16 in.
L1620 Hip orthosis, immbolizer, canvas longitudinal
L1830 Knee orthosis, immobolizer, canvas longitudinal
L1902 Ankle foot ortho ankle gauntlet, prefab fit
L3140 Foot rotation positioning device, including shoe
L3908 Wrist hand orthosis exten. control ...

Miscellaneous Code Changes Effective April 1, 2003

20551 Injection, tendon insertion opened
36415 Routine venipuncture had a descriptor change to remove or finger/heel/ear stick. This part of the code was transfered to code 36416. Since routine venipuncture is covered by code G0001, code 36415 is now closed.

Percutaneous Central Venous Line Placement

36488 Central venous line placement, percutaneous, age 2 years or under
36489 Central venous line placement, percutaneous, over age 2

The editing program has been making procedure codes 36488 and 36489 incidental to the evaluation and management service, surgical procedure, or anesthesia. The decision has been made to override this edit. Beginning April 1, 2003, payment will then be allowed for code 36488 or 36489 in addition to the E&M, anesthesia or surgery code.

Physician Manual, SECTION 2, Addendums

under Covered Service (page 12)

23. ... The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. ...

under **Specific Non-covered Services**: (page 40)

> u. Treatment and evaluations of subluxation or flat feet. Treatment of flat foot is a condition in which one or more arches in the foot have flattened out. Surgical or nonsurgical treatments undertaken for the purpose of correcting a subluxated structure in the foot or devices directed toward care or correction of this condition, including prescription of supportive devices are not covered.

New Criteria or Changes to Existing Criteria

Neurostimulators

Beginning April 1, 2003, prior approval for Implantation of Vagal Neurostimulator, code Procedure 64573, and implantation of spinal neurostimulators, procedure code 63650 and 63655, and sacral or pelvic neurostimulators, codes 64561 and 64581, **will require review by the Utilization Review Committee and written prior approval through the committee.** The vagal neurostimulator has been implanted outside of FDA guidelines and the Utah Medicaid criterion #32A. The neurostimulator is only approved for implantation in patients with intractable partial epilepsy with one identified focus or localized site of seizure activity. **Neurostimulators are not approved for generalized seizures.** In order to maintain some control over this procedure written prior approval will be required. The following information has been added to Criteria 32A# related to vagal neurostimulators: Neurostimulators are not approved for generalized seizures, one focal or localized site of seizure activity must be identified. Since there are multiple new drugs, several of these drugs must be tried. Medical record documentation should include the drugs (new and established) which were tried, in what combinations and for how long. Include monitored therapeutic levels if available. If quality of life measurements were taken, which standardized tests, and with what results?

Spinal neurostimulators have also been implanted outside of criterion 32C. These neurostimulator approval requests will require presentation and discussion in UR Committee and written approval provided through the committee.

Sacral neurostimulators, procedure code 64561 and 64581, criterion describes the requirement for a trial of the percutaneous device (64581) with prior approval. Approval of the permanent device (64561) requires review of medical record documentation describing the effectiveness of the percutaneous device. Written prior approval through UR committee is required prior to implantation of the permanent sacral neurostimulator. Please refer to criterion 32 B page 29 of the physician provider manual.

Outpatient facilities and hospitals will need to ensure prior written approval has been provided prior to implantation of the neurostimulator. In cases where the device has been implanted without written prior approval, reimbursement funds will be recovered for the cost of the device as well as the surgical services rendered through the hospital or outpatient facility. Please refer to Criteria 32A, 32B, 32C Page 28-30.

Cardiac Ablation–Criteria #38

Catheter ablation is a therapeutic technique using an electrode catheter which generates a high level of direct current or radio frequency to destroy the arrhythmic area in the heart in order to eliminate conduction defects which cause tachycardia. The CPT codes which describe catheter ablation of cardiac arrhythmic focus include procedures 33250, 33251, 33261, 93650, 93651, and 93652.

A. Coverage and limitations:

1. Documentation must support the medical necessity of the catheter procedure based on **chronic, symptomatic recurrent arrhythmia which is refractory to cardioversion and drug therapy** or the drug therapy is contraindicated. The following arrhythmia's are covered for catheter ablation:
   - Supraventricular atrial or sinoatrial tachyarrhythmia's (SVT) in patients resistant to drug therapy with symptomatic recurrent SVT.
   - Atrioventricular nodal ablation carries less certainty of benefit but may be considered medically necessary in patients with a dual chamber pacemaker who have pacemaker-mediated tachycardia which cannot be treated effectively with drugs or by reprogramming the pacemaker
   - Tachycardia with syncope or Wolfe-Parkinson-White.
   - Atrial tachycardia with rapid ventricular response or patients resuscitated from cardiac arrest due to atrial flutter or atrial fibrillation with rapid ventricular response in the absence of an accessory pathway.
   - Patients with an identifiable focus for chronic or recurrent ventricular tachycardia (VT)
2. The procedure maybe medically necessary in cases of refractory atrial flutter or fibrillation in which the ventricular rate cannot be medically controlled by cardioversion and drug therapy. The procedure may be recommended for atrial flutter with paroxysmal atrial fibrillation when the tachycardia is drug intolerant or drug resistant. Catheter ablation is indicated for atrial fibrillation when the tachycardia is drug resistant and there is evidence of a localized site of origin.

B. Non-covered:

1. Patients with ventricular and atrial tachyarrythmias that are responsive to drug therapy and/or cardioversion.
2. The patient has unstable, rapid, multiple, or polymorphic VT that cannot be adequately localized with mapping techniques.
3. The patient has multifocal atrial tachycardia (MAT)
4. The patient has benign non-sustained VT that does not cause symptoms.
5. Other uses of radiofrequency catheter ablation are considered investigational procedures

ICD9 codes supporting medical necessity:

426.7 anomalous atrioventricular excitation (Wolff-Parkinson-White syndrome)
426.89 other specified conduction disorders: atrioventricular, isorhythmic, nonparoxysmal AV nodal tachycardia
427.0 Paroxysmal supraventricular tachycardia, paroxysmal tachycardia: atrial (PAT), atrioventricular (AV), junctional, nodal
427.1 Paroxysmal ventricular tachycardia
427.31 Atrial fibrillation
427.32 Atrial flutter

UltraSounds in Pregnancy Criteria #39

Since the introduction of ultrasound into obstetrics, it has become a valuable tool for the evaluation of mother and the fetus. However, recent review of use indicates that the procedure has been completed multiple times as a routine procedure without indications of medical necessity. According to the ACOG Committee on Obstetrics, ultrasound should only be performed when there is diagnostic information to be obtained. The National Institutes of Health consensus conference recommends ultrasound in pregnancy be completed for a specific medical condition and not for routine screening. If an abnormality is found during the office scan, the patient should be referred to a perinatologist or perinatal center for a definitive diagnosis.

A. Coverage

- Effective January 1, 2003, one routine office ultrasound will be allowed for all pregnant women at about 20 weeks to estimate gestational age, detect multiple gestations, and fetal malformations or an evaluation for fetal condition in women obtaining late prenatal care. The screening ultrasound should be submitted with the addition of the diagnosis code V22.0, V22.1, or V23.3.
- Further ultrasounds require submission of documentation for medical necessity and prior approval. When medical necessity is indicated, the additional ultrasound testing must be completed through a perinatologist or perinatal center unless prior authorization is given.
- There is one exception to the stipulation one ultrasound is permitted without prior authorization. In approximately 20% of patients, bleeding or pain may occur at eight to 12 weeks gestation. Since the differential diagnosis may include ectopic pregnancy or miscarriage, an ultrasound is a medically necessary covered service. This patient is also allowed the ultrasound at about 20 weeks gestation without prior authorization.

B. Indications

1. Placenta previa found at the 18-20 week scan should be followed up with a scan in the third trimester for placental location. If the woman has had a prior C-section or the placenta previa is central, documentation should be submitted for medical review.
2. Patients with an incompetent cervix must be referred to a perinatal center for a transvaginal scan.
3. If the fetus is not growing it may represent IUGR (intrauterine growth restriction). Repeat ultrasound may be recommended once per month in the third trimester. More frequent ultrasounds require physician review.
4. Documentation of the medical necessity must be submitted for medical review with requests for a repeat ultrasound in cases involving maternal risk factors such as diabetes or hypertension.
5. Appropriate indications for ultrasound in the first trimester include ectopic pregnancy, spontaneous abortion (threatened, incomplete, missed), molar pregnancy, first trimester bleeding, and intrauterine device.

C. Limitations

1. Ultrasound scans completed in the office are limited to normal scans. If a repeat scan is medically necessary, the patient should be referred to a perinatal center for the ultrasound.
2. **One ultra sound is covered in a patient less than 14 weeks gestation who is symptomatic for ectopic pregnancy or miscarriage.** Procedure code 76801 with or without procedure code 76802 **OR** procedure code 76817 are covered services under these conditions
3. Abdominal scans do not diagnosis an incompetent cervix and are non-covered.
4. Ultrasounds completed for the purpose of obtaining a picture of the fetus or sex determination are not covered.
5. When a limited ultrasound 76815 and followup or repeat ultrasound 76816 are billed on the same date, the repeat ultrasound will be denied. Documentation supporting medical necessity will be reviewed on appeal.

Imaging Criteria #40

A. CT Scans

Chest: The criterion applies to Thoracic CT scans, CPT such as codes 71250, 72160, and 71270

Indications

a. In the majority of circumstance the CT will follow chest x-rays to further establish a diagnosis on identified abnormalities. Posterior and lateral views of the chest represent the basic screening tool in identifying abnormalities involving the thorax. It is expected that the chest x-ray is used to evaluate patients who present with signs and/or symptoms suggestive of chest pathology prior to proceeding to a CT scan. However, in limited circumstances, a CT of the Thorax may be used as a primary diagnostic tool if the documentation supports that the initial test was reasonable and necessary and the medical literature supports the CT scan as the primary diagnostic test for the condition being evaluated.
b. The use of the scan must be medically appropriate considering the patients symptoms and preliminary diagnosis. Documentation in the medical record should support the reasoning behind the decision for the CT scan.
c. It is expected that the ordering physician and the radiologist(s) involved are aware of local and national medical review policies related to CT procedures.
d. CT may be indicated as medically necessary when:
   - there is a suspected mass or growth
   - clinical indicators suggest a possible metastasis to the pulmonary system from a known neoplasm site such as brain or breast
   - evidence of a growth or mass requires biopsy guidance
   - the progression of a disease requires evaluation such as pulmonary fibrosis
   - clinical signs suggest pulmonary collapse (pneumothorax) or a lung abscess (empyema).
e. CT may be useful for the patient presenting with chest pain when the differential diagnosis includes pulmonary embolism or aortic aneurysm and/or following trauma when an internal injury of the thorax is suspected.
f. CT of the thorax may be advisable prior to bronchoscopy when a patient is HIV positive with suspected pulmonary tuberculosis and the chest film has non specific interstitial infiltrates or the film is abnormal and it is difficult to identify whether there is cavitation.

Limitations

1. It is expected that the ordering physician and the radiologist(s) involved are aware of local and national medical review policies related to CT procedures.
2. The frequency of the exam must be reasonable and justified upon intermediary medical review.

Non Coverage

1. A thoracic CT scan is not covered as a screening test in the absence of signs or symptoms of a disease or condition. CT of the thoracic for investigational or clinical trial purposes is not covered, including lung cancer screening or as part of the evaluation of a procedure or a clinical drug trial.
2. A thoracic CT is not covered when the purpose is a sharper image of the chest x-ray.
3. There are no protocols for use of Thoracic CT for tuberculosis or other infectious disease screening through the Centers for Disease Control and Prevention or the American College of Radiology. The chest x ray is the standard of practice. A review for medical necessity of CT of the thorax may be requested for a particular case.

Body

1. Screening CT scans of the body are not covered by Utah.
2. Any anatomical site receiving CT scanning must have documentation supporting medical necessity.

B. MRI

Limitations and noncoverage:

1. Reasonable imaging studies should be completed prior to the decision for an MRI. MRI must be medically necessary and a reasonable test to order based on the diagnosis. Bone detail is better imaged by conventional x-rays or CAT scan. CT is preferred for unstable patients with severe bleeding and when calcification is present. MRI is less sensitive in distinguishing between tumor tissue and edema fluid, and in detecting small abnormalities ((poor spatial resolution) compared to CT scan.
2. Evaluation of uncomplicated degenerative disc disease or herniated nucleus pulposis is not considered medically necessary.
3. MRI is a non-covered service when completed for the measurement of blood flow, spectroscopy, imaging cortical bone, and calcifications, and procedures involving spatial resolution of bone or calcifications.

Body

1. Screening MRI scans of the entire body are not covered by Utah.
2. Any anatomical site receiving MR imaging must have documentation supporting medical necessity.

Spine

Coverage

1. For the patient with low back pain syndrome where

there is no known cancer or septic disorder and there are no symptoms suggesting nerve, nerve root, or spinal cord dysfunction, MRI may be medically reviewed for coverage if the patient has not responded to a least a three month trial of conservative treatment.

2. An appropriate diagnosis must be submitted with the claim and the medical record must indicate the clinical signs and symptoms that support the medical necessity and reasonableness of ordering the MRI test. The patients record must show clinical evidence of myelopathy and/or radiculopathy, if the MRI is performed for evaluation of degenerative disc disease or herniated nucelus pulposus.

Indications

1. Degenerative or demyelinating diseases of the spinal cord
2. Vertebral inflammatory lesions (i.e. epidural abscess, osteomyelitis)
3. Congenital malformations
4. Intramedullary lesions such as syringomyelia
5. Neoplasms of spine and spinal cord
6. Spinal trauma
7. Spinal stenosis
8. Myelopathy

Fiberoptic Endoscopic Evaluation of Swallowing (FEESST), Criteria #41:

Fiberoptic endoscopic evaluation of swallowing with sensory testing (FEESST) is an alternative to modified barium swallow evaluation for patient at risk of aspiration. Videofluoroscopy has long been viewed as the "gold standard" for evaluation of a swallowing disorder for the comprehensive information it provides. However, it is not very efficient and accessible in certain clinical and practical situations. Fiberoptic endoscopic evaluation of swallowing (FEES) has been shown to be safe and effective for assisting in swallowing evaluation, and in therapy as a visual display to help patients learn various swallowing maneuvers. A specially equipped flexible endoscope is passed into the oropharynx. The specialty equipment includes a sensory stimulator, a television monitor, a video printer, and a videocassette recorder. The CPT codes involved are 31575, 92520, 92610, 92612, 92613.

Indications and Coverage:

1. Conditions in which patients may benefit from the procedure:
    - Stroke or other central nervous system disorders which affect swallowing and speech
    - Patients without an obvious CNS disorder with difficulty in swallowing, a clinical history or aspiration, or a history of aspiration pneumonia
    - Presence of oral motor disorders with symptoms such as drooling of food or liquids placed in the mouth or oral food retention
    - Lack of coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting the ability to close the buccal cavity, bit, chew, suck, shape or squeeze a food bolus into the upper esophagus while protecting the airway.
    - To visualize the larynx directly for signs of trauma or neurologic damage and assess laryngeal competence post-surgery where the laryngeal nerve was vulnerable.
2. The diagnosis or clinical suspicion of aspiration must be present for the procedure to be considered medically necessary. Medical record documentation must support the medical necessity and describe why the FEEST procedure provides more information and benefit than barium swallow evaluation studies.
3. The results of FEEST testing will impact the clinical decisions affecting the daily dietary management of the impaired patient and have an impact on the evaluation and management of therapy programs.

Limitations and Non Coverage

a. These services are limited to physicians. Incident to services cannot be billed.
b. The use of topical anesthesia may interfere with sensory testing and is usually not indicated.
c. FEESST is not recommended when pathology such as an esophageal lesion is suspected.
d. The procedure is not covered for routine screening or when preformed in the absence of a specific sign or symptom supporting medical necessity.
e. Services ordered for diagnoses not listed as covered in this policy, or for excessive frequency, will be denied as not medically necessary, unless documentation is submitted to support the claim.
f. The clinical effectiveness and applicability of the addition of sensory testing to the FEES procedure have not been determined. Therefore, CPT codes 92614 through 92617 are not covered services.

ICD9 codes supporting medical necessity

438.11 Late effects of CVA, Aphasia
432.12 Late effects of CVA, Dysphasia
438.82 Dysphagia cerebrovascular disease
507.0 Pneumonitis due to inhalation of food or vomitus
783.3 Feeding difficulties and mismanagement
787.2 Dysphagia
933.1 Foreign body in larynx
934.0 Foreign body in trachea
934.1 Foreign body in main bronchus
934.8 Foreign body in other specified parts of bronchus and lung
934.9 Foreign body in respiratory tree unspecified

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03 - 24 Medicaid Prospective Payment System - On the Basis of Encounters Applies to Federally Qualified Health Centers (FQHCs) & Rural Health Centers (RHCs)

The Benefits Improvement and Protection Act of 2000 (BIPA) replaced the requirement for cost-based reimbursement with a new prospective payment system (PPS) that is effective for services provided beginning January 1, 2001. Under the PPS, the first year's payment is set at an FQHCs or RHCs average cost per visit for 1999 and 2000. Future years' payment rates are adjusted annually for inflation, and when necessary, for changes in the scope of services. The information covered here will not cover all aspects of the Act, and the implementation, but only a few areas where misunderstandings seem to exist.

One area of confusion is understanding an encounter or visit. This is a physicians direct service to a patient or the direct service of an allowable non-physician acting under the supervision of a physician. The following commentary may help to understand how that is applied.

(See State Plan 3.1-A(attachment #5) re: physician services):
Physician services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by an individual licensed to serve the health care needs of a practice population under a physician's supervision.

a. "Personal Supervision" means: The critical observation and guidance of medical services by a physician of a non-physician's activities to assure that the health, safety and welfare of patients is not compromised.

The acceptable standard of supervision is availability by telephone when the physician maintains written protocols embodying care standards and supervisory procedures along with the Delegation of Services Agreement maintained at the practice site. Medical records must have sufficient documentation signed by the physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision.

b. "Direct Supervision" means: The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

When licensure laws, policy, education protocols, coding definitions, or service being provided require "Direct Supervision", the acceptable standard of supervision is availability in the facility, not necessarily within the same room, but within 10 minutes of reaching the person being supervised to provide assistance, consultation or direct care. Medical records must have sufficient documentation signed by the physician to reflect presence and participation of the physician in direct supervision.

The above described visit of a physician with a patient is considered to be an encounter. Other visits by licensed providers who render allowable, specialty medical services to patients, such as; psychiatric services, dental services, etc. are also considered encounters.

To qualify as an encounter, the services rendered must be the kinds commonly furnished by physicians (to include supervised non-physician nurse practitioners and physician assistants). Things that physicians generally do not do, such as; injections, immunizations, etc., that are normally performed by a nurse or medical assistant, do not qualify as encounters.

Therefore, the supervised services rendered by RNs, LPNs, and MAs, while still required for patient care, are not recognized as encounters for billing purposes.

This is where some of the confusion comes about. How can a clinic recover their cost for services rendered that cannot be billed as an encounter? The following is an explanation of how that works:

As noted above, the PPS rate (payment for each encounter) is an average cost per visit. The cost includes all elements of cost such as; facility rents, utilities, payroll, payroll benefits, outside services, supplies, etc. When the total cost is divided by total visits (encounters) for the same period of time, the PPS rate derived includes the elements of all costs, not just the physician costs. Therefore, each encounter billed represents elements of all costs.

One of the major areas some provider billing specialists are confused about is the billing of immunizations generally with regards to the Vaccine For Children (VFC) program. The VFC vaccine is given to providers free so all they can bill to Medicaid is the administration portion, and that does not qualify as an encounter. However, as explained above, although the

cost is not reimbursed directly by a specific billing, it is reimbursed through a portion of all encounters billed.

Prior to changing to the PPS methodology, FQHCs and Provider based RHCs billed Medicaid on the basis of charges by CPT codes. During the meetings and discussions held preceding implementation of the PPS, the FQHC industry, as a group, decided they wanted to continue billing all charges, as they had in the past, and just add the "T1015" code where the billing qualified as an encounter. This was acceptable with Medicaid since the "T" code is the only code recognized as an encounter for payment. Since implementation, however, some FQHCs have decided to only bill encounters which creates another problem. When immunization encounters are not billed, the ability to track the immunizations is lost.

We believe it to be in the best interest of both the Providers and the State for Providers to bill all charges (especially the immunizations) for tracking and control purposes. Certain system edits do not work when only the "T" codes are billed, particularly with regards to diagnosis codes provided when CPT charges are billed. The State also finds that immunization codes must be billed for tracking purposes as noted above. Therefore, as a minimum, the immunization codes must be billed by CPT codes but with no "T1015" encounter code.

Another problem experienced is certain FQHCs are billing immunizations and are applying the "T" code and are being reimbursed an encounter rate for the billing. This is illegal and if it continues on a regular basis, whether CPT codes are included or not, could be deemed as Medicaid Fraud. While the auditing of FQHCs and RHCs has been drastically reduced, it is planned to do some block tests of provider billings and validate them to the source, signed medical records and charts.

One subject that has caused some concern is in the urban areas where FQHC physicians have regular visit with pregnant women and eventually deliver their babies. Prior to PPS, the charges for visits were zero ($0.00), however; the delivery was chargeable on a global fee basis. After PPS, it is required to charge an encounter for each visit (including post delivery) as well as only one encounter for the delivery.

The timing between the effective date and PPS implementation has also caused some confusion among those using the system. The Act required the PPS system to go into effect as of January 1, 2001. Since States were not notified of this change until December of year 2000, it was not possible to implement it the following month. It required a period of educating, planning and programming. During this period clinics had to continue billing in their traditional manner. The State went on line with the PPS for RHCs on 1 April 2002 and for FQHCs on 1 May 2002 which was 15 and 16 months, respectively, after the effective date. For those 15 and 16 month periods, Medicaid has since gone back and converted charges to encounters, where applicable, and determined settlement differences between what was paid and what should have been paid using the calculated PPS rates. This procedure is still in process of being completed for some facilities.

The billing of CPT code charges may create an accounting problem with some providers depending on the computer software and accounting procedures in place. Many systems require a monetary value be billed. This can be satisfied by billing normal charges or only 1 cent. The accumulation of these charge amounts must be written off either on a manual basis or by the computer since they will not be collected through the normal accounts receivable process. ☐

Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing issues separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. The bulletins are mailed only to enrolled providers who are affected by the change.

The April 2003 **NTM** bulletin will be issued to the following provider types: Pharmacy; Physicians

The April 2003 **PCN** bulletin will be issued to the following provider types: Dental; Hospital; Pharmacy; Physician.

All bulletins are available on the Medicaid Provider's web site:
http://health.utah.gov/medicaid/html/provider.html

Bulletins are under the headings Medicaid Information Bulletins, Non-Traditional Medicaid Plan, and Primary Care Plan. Contact Medicaid Information if you want a printed NTM or PCN bulletin that is not included with this Medicaid bulletin.